Do Not Staple!

OPEN ENROLLMENT/NEW HIRE APPLICATION VALID FOR USE FROM 10/1/2008 – 12/31/2008

KENTUCKY EMPLOYEES HEALTH PLAN

PY 2009

ENROLLMENT APPLICATION

FOR ACTIVE EMPLOYEES

INSURANCE COORDINATOR SECTION **REQUIRED**

__/__/0__ Coverage Effective Date

_____ Company Number

Reason for Application:

☐ < New Employee ☐ < Open Enrollment ☐ < New Group ☐ < FSA Only

☐ < QE* ☐ < Previously Waived* ☐ < Other*

* If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event Date AND a description of the Qualifying Event: _____ Date _____ Qualifying Event Description

SECTION I: DEMOGRAPHIC INFORMATION → Please PRINT

___-___-____ Social Security Number

__/__/____ Date of Birth (MM/DD/YYYY)

Smoking Status *(Required)*

Have you smoked in the last 2 months? ☐ < Yes ☐ < No

_____

NAME (First, MI, Last)

_____

Mailing Address

Gender

☐ < Male

☐ < Female

Marital Status

☐ < Married

☐ < Single

_____ City, State, Zip Code

_____ County of Residence

_____ Country / Mail Code, if not USA

_____ Planholder's HOME Phone Number

_____ Planholder's WORK Phone Number

_____ Planholder's Email Address (prefer Work Email Address)

_____ Hire Date

_____ Employer Name

_____ Work County

SECTION II: PLAN SELECTION → *If you wish to waive (i.e. decline) coverage, skip to Section V below*

1. Option (Check only one)

☐ < Commonwealth Standard PPO

☐ < Commonwealth Capitol Choice

☐ < Commonwealth Optimum PPO

☐ < Commonwealth Maximum Choice

2. Level of Coverage

☐ < Single

☐ < Parent Plus

☐ < Couple

☐ < Family

3. Cross-Reference Payment Option

(Available for Family Coverage Only)

☐ < Yes

If Yes, you must complete Sections III and IV

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → *If you selected Single coverage, skip to Section VI*

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		
		M F		

Relationship Codes: SP = Spouse, CH = Child, DD = Disabled Dependent, CO = Court-Ordered Dependent

SECTION IV: CROSS-REFERENCE INFORMATION → *Complete ONLY if you checked Yes in Section II, box 3*

Your Spouse's Company Number: ***(Required)***	Has your spouse smoked in the last 2 months? ***(Required)***	Is your spouse a Hazardous Duty Retiree?	Your spouse's Hire Date or Retirement Date:
_____	☐ <Yes ☐ <No	☐ <Yes ☐ <No	_____

SECTION V: WAIVER → *Complete this section only if you did not select coverage in Section II*

Do you wish to waive (i.e. decline) your coverage and have the employer contribution of $175 per month deposited into a Health Reimbursement Account (HRA), ***if eligible***? *(If not eligible, you will be set up as a **Waiver with no HRA**).* ☐ < Yes

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Planholder's SSN

SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA) → Enrollment in an FSA is OPTIONAL

If you are an employee of a health department or certain quasi agencies, this section does not apply to you. You must contact your insurance coordinator regarding your employer's FSA enrollment process.

Healthcare FSA → All amounts must be divisible by two and be listed for a full calendar year.
The **maximum** allowable yearly contribution is $5,000

Planholder	**Spouse** → If paying by cross-reference and spouse's FSA program is administered by the KEHP
Total Employee Contribution for Calendar Year 1/1-12/31 _____	Total Spouse Contribution for Calendar Year 1/1-12/31 _____

Dependent Care FSA → All amounts must be divisible by two.
The **maximum** allowable yearly contribution (per family) based on tax filing status

Tax Filing Status:

☐ < Married, filing separately (max = $2,500) ☐ < Married, filing jointly (max = $5,000) ☐ < Single, head of household (max = $5,000)

Planholder	**Spouse** → If paying by cross-reference and spouse's FSA program is administered by the KEHP
Total Employee Contribution for Calendar Year 1/1-12/31 _____	Total Spouse Contribution for Calendar Year 1/1-12/31 _____

HumanaAccess℠ VISA® Card
Upon enrolling in an HRA or a **healthcare** FSA you will Receive the HumanaAccess- Visa® card at no cost to you.

SECTION VII: AUTHORIZATION AND CERTIFICATION

* I understand that my signature on this application creates a legal and binding contract between myself, the Department for Employee Insurance and the TPA.
* **I understand that if my spouse and I elect the cross-reference payment option, we are dual plan holders and our level of coverage (Family) will automatically drop to a parent plus coverage level upon termination of employment by either spouse/planholder. The cross-reference payment option ceases upon termination of employment by either spouse/planholder.**
* I understand that each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP handbook.
* I understand that all benefits for my eligible dependents and me will be provided in accordance with the plan document.
* I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that the elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
* I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected.
* **I elect to have the employee contribution for health coverage deducted on a pre-tax basis unless I sign a Post-Tax Form or otherwise acknowledge post-tax treatment for my dependents. For Pre-tax treatment, dependent coverage must meet eligibility requirements of section 152.**
* I understand that enrollment in an FSA is optional and that by completing Section VI of this application, I am enrolling in an FSA, if eligible to participate.
* Regarding my FSA, I understand that any dependents for which I claim reimbursement are Section 152 dependents as defined by the Internal Revenue Code.
* Regarding my FSA, I further understand that any unused amount remaining in my spending account at the end of the plan year cannot be carried forward to the next year due to the Commonwealth's Cafeteria Plan Document.
* I understand that I have a 90-day run-out period (until March 31) for reimbursement of eligible FSA expenses incurred during my period of coverage.
* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
* I understand that this plan has a tobacco incentive for members that do not use tobacco and that this plan offers tobacco cessation programs.
* I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.

_____ _____
Employee Signature Date

_____ _____
Spouse Signature – ***REQUIRED*** **if electing the cross-reference payment option** Date

.....

I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP. My signature below certifies that all signatures and signature dates affixed to this contract are correct to the best of my knowledge.

_____ _____
Employee's Insurance Coordinator Signature Date

_____ _____
Spouse's Insurance Coordinator Signature – ***REQUIRED*** **if electing the cross-reference pmt. option** Date